



GEORGIA MEDICAID FEE-FOR-SERVICE HIV-AIDS PA SUMMARY

Preferred (may not be all inclusive)	Non-Preferred
Abacavir generic	Abacavir/lamivudine/zidovudine generic
Abacavir/lamivudine generic	Aptivus (tipranavir)
Atazanavir capsules generic	Complera (emtricitabine/rilpivirine/tenofovir disoproxil fumarate)
Atripla (efavirenz/emtricitabine/tenofovir disoproxil fumarate)	Crixivan (indinavir)
Biktarvy (bictegravir/emtricitabine/tenofovir alafenamide)	Delstrigo (doravirine/lamivudine/tenofovir disoproxil fumarate)
Cimduo (lamivudine/tenofovir disoproxil fumarate)	Fuzeon (enfuvirtide)
Descovy (emtricitabine/tenofovir alafenamide)	Intelence (etravirine)
Dovato	Invirase (saquinavir)
Edurant (rilpivirine)*	Lexiva (fosamprenavir)
Efavirenz tablets generic	Nevirapine extended-release generic
Emtriva (emtricitabine)	Norvir Powder (ritonavir)
Epivir solution (lamivudine)	Pifeltro (doravirine)
Evotaz (atazanavir/cobicistat)*	Reyataz Powder (atazanavir)
Genvoya (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide)	Ritonavir tablets generic
Isentress and Isentress HD (raltegravir)*	Rukobia (fostemsavir)
Juluca (dolutegravir/rilpivirine)	Selzentry (maraviroc)
Kaletra (lopinavir/ritonavir)	Stavudine generic^
Lamivudine generic	Stribild (elvitegravir/cobicistat/emtricitabine/ tenofovir disoproxil fumarate)
Lamivudine/zidovudine generic	Symfi (efavirenz 600 mg/lamivudine/tenofovir disoproxil fumarate)
Nevirapine immediate-release tablets generic	Symfi Lo (efavirenz 400 mg/lamivudine/tenofovir disoproxil fumarate)
Norvir (ritonavir)	Temixys (lamivudine/tenofovir disoproxil fumarate)
Odefsey (rilpivirine/emtricitabine/tenofovir alafenamide)*	Videx Solution (didanosine)
Prezcobix (darunavir/cobicistat)*	Vitekta (elvitegravir)
Prezista (darunavir)*	
Rescriptor (delavirdine)	
Sustiva capsules (efavirenz)	
Symtuza (darunavir/cobicistat/emtricitabine/ tenofovir alafenamide)	
Tenofovir disoproxil fumarate 300 mg tablets generic	
Tivicay (dolutegravir tablets)	
Tivicay PD (dolutegravir tablets for oral suspension)*	
Triumeq (abacavir/dolutegravir/lamivudine)	



Trizivir (abacavir/lamivudine/zidovudine)	
Truvada (emtricitabine/tenofovir disoproxil fumarate)	
Tybost (cobicistat)*	
Videx EC (didanosine)	
Viracept (nelfinavir)	
Viramune Suspension (nevirapine)	
Viread Powder and Tablets 150 mg, 200 mg, 250 mg (tenofovir disoproxil fumarate)	
Ziagen Solution (abacavir)	
Zidovudine generic	

*preferred but requires PA; ^non-preferred but does not require PA

LENGTH OF AUTHORIZATION: Varies

NOTE:

- Prior authorization (PA) approval may be considered for continuation of therapy from another insurance plan or ADAP (AIDS Drug Assistance Program).
- Edurant, Evotaz, Isentress, Odefsey, Prezcobix, Prezista, Tivicay PD and Tybost are preferred but require prior authorization.

PA CRITERIA:

Abacavir/Lamivudine/Zidovudine Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand Trizivir, is not appropriate for the member.

Aptivus

- ❖ Approvable for members 2 years of age or older for treatment of HIV infection when used in combination with ritonavir and one or more other antiretrovirals

AND

- ❖ Member's HIV must be resistant to at least 2 other protease inhibitors (PIs).

Complera

- ❖ Approvable for prophylaxis following exposure to HIV.
- ❖ Approvable for members 12 years of age or older who weigh 35 kilograms or more for treatment of HIV infection

AND

- ❖ For treatment-naïve, member's baseline HIV RNA level must be $\leq 100,000$ copies/mL and baseline CD4+ cell count must be ≥ 200 cells/mm³. For treatment experienced, member must have consistent viral suppression (HIV RNA < 50 copies/mL) for ≥ 6 months with no history of virologic failure

AND

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, Odefsey as well as Edurant taken with Descovy or Truvada, are not appropriate for the member.



Crixivan

- ❖ Approvable for members 18 years of age or older for treatment of HIV infection when used in combination with ritonavir and one or more other antiretrovirals

AND

- ❖ Member's HIV must be resistant to at least 2 other protease inhibitors (PIs).

Delstrigo and Pifeltro

- ❖ Approvable for members 18 years of age or older for treatment of HIV infection who are treatment-naïve or are virologically suppressed (HIV RNA <50 copies/mL) on a stable antiretroviral regimen with no history of treatment failure and are resistant to or have an allergy, contraindication, drug-drug interaction or intolerable side effect to bicitgravir, emtricitabine or tenofovir alafenamide (Biktarvy).
- ❖ In addition for Pifeltro, must be used in combination with one or more other antiretrovirals.

Edurant

- ❖ Approvable for prophylaxis following exposure to HIV when used in combination with other antiretrovirals.
- ❖ Approvable for members 12 years of age or older who weigh 35 kilograms or more for treatment of HIV infection when used in combination with other antiretrovirals.

AND

- ❖ For treatment-naïve, member's baseline HIV-RNA level must be $\leq 100,000$ copies/mL and baseline CD4+ cell count must be ≥ 200 cells/mm³. For treatment experienced, member must have consistent viral suppression (HIV RNA < 50 copies/mL) for ≥ 6 months with no history of virologic failure.

Evotaz and Prezcobix

- ❖ Approvable for members 12 years of age or older for treatment of HIV infection when used in combination with other antiretrovirals.

Fuzeon

- ❖ Approvable for prophylaxis following exposure to HIV when used in combination with other antiretrovirals.
- ❖ Approvable for members 6 years of age or older for treatment of HIV infection when used in combination with other antiretrovirals

AND

- ❖ Member must be HIV treatment-experienced and resistant to at least 2 other HIV treatments.

Intence

- ❖ Approvable for prophylaxis following exposure to HIV when used in combination with other antiretrovirals.
- ❖ Approvable for members 6 years of age or older for treatment of HIV infection when used in combination with other antiretrovirals

AND

- ❖ Member must be HIV treatment-experienced and resistant to at least 2 other non-nucleoside reverse transcriptase inhibitors (NNRTIs).



Invirase

- ❖ Approvable for members 2 years of age or older for treatment of HIV infection when used in combination with ritonavir and one or more other antiretrovirals

AND

- ❖ Member's HIV must be resistant to at least 2 other protease inhibitors (PIs).

Isentress

- ❖ Approvable for prophylaxis following exposure to HIV when used in combination with other antiretrovirals.
- ❖ Isentress tablets are approvable for members 6 years of age or older for treatment of HIV infection when used in combination with other antiretrovirals.
- ❖ Isentress chewable tablets and powder are approvable for members less than 12 years of age for treatment of HIV infection when used in combination with other antiretrovirals.

Isentress HD

- ❖ Approvable for prophylaxis following exposure to HIV when used in combination with other antiretrovirals.
- ❖ Approvable for members 18 years of age or older for treatment of HIV infection who are treatment-naïve or virologically suppressed on Isentress 400 mg twice daily when used in combination with other antiretrovirals.
- ❖ Approvable for members less than 18 years of age and weigh 40 kg or greater for treatment of HIV infection who are treatment-naïve or virologically suppressed on Isentress 400 mg twice daily when used in combination with other antiretrovirals.

Lexiva

- ❖ Approvable for members 2 years of age or older for treatment of HIV infection when used in combination with ritonavir and one or more other antiretrovirals

AND

- ❖ Member's HIV must be resistant to at least 2 other protease inhibitors (PIs).

Nevirapine ER Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic nevirapine immediate-release tablets, is not appropriate for the member.

Norvir Powder

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Norvir Solution, is not appropriate for the member.

Odefsey

- ❖ Approvable for prophylaxis following exposure to HIV.
- ❖ Approvable for members 12 years of age or older who weigh 35 kilograms or more for treatment of HIV infection

AND

- ❖ For treatment-naïve, member's baseline HIV RNA level must be $\leq 100,000$ copies/mL and baseline CD4+ cell count must be ≥ 200 cells/mm³. For treatment experienced, member must have consistent viral suppression (HIV RNA < 50 copies/mL) for ≥ 6 months with no history of virologic failure.



Prezista

- ❖ Approvable for members 3 years of age or older for treatment of HIV infection when used in combination with other antiretrovirals.

Reyataz Powder

- ❖ Approvable for members 3 month of age or older for treatment of HIV infection who weigh 5 kg to less than 25 kg or who weigh 25 kg or more and are unable to swallow solid oral dosage formulations (i.e., capsules, tablets).

Ritonavir Tablet Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand Norvir, is not appropriate for the member.

Rukobia

- ❖ Approvable for members 18 years of age or older for treatment of HIV infection, when used in combination with other antiretroviral(s), who are heavily treatment-experienced with multidrug-resistant HIV-1 infection failing their current antiretroviral regimen due to resistance, intolerance or safety considerations and who have a viral load (HIV RNA) ≥ 400 copies/mL and ≤ 2 classes of antiretroviral medications remaining.

Selzentry

- ❖ Approvable for prophylaxis following exposure to HIV when used in combination with other antiretrovirals.
- ❖ Selzentry tablets are approvable for members 2 years of age or older for treatment of CCR5-tropic HIV infection when used in combination with other antiretrovirals.
- ❖ Selzentry oral solution is approvable for members 2 to 11 years of age for treatment of CCR5-tropic HIV infection when used in combination with other antiretrovirals, and for members 12 years of age or older who are unable to swallow solid oral dosage formulations (i.e., capsules, tablets) when used in combination with other antiretrovirals.

Stribild

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Genvoya, is not appropriate for the member.

Symfi and Symfi Lo

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the individual preferred products, efavirenz generic, lamivudine generic and tenofovir disoproxil fumarate generic taken together, are not appropriate for the member.

Temixys

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, Cinduo and lamivudine generic with tenofovir disoproxil fumarate generic, are not appropriate for the member.

Tivicay PD

- ❖ Approvable for members 4 weeks to 17 years of age who weigh 3 kg to 19 kg.



- ❖ Approvable for members 4 weeks to 17 years of age who weigh 20 kg to 24 kg and are unable to swallow solid oral dosage formulations (i.e., capsules, tablets).

Tybost

- ❖ Approvable for members 18 years of age or older for treatment of HIV infection when used in combination with atazanavir or darunavir.

Videx Solution

- ❖ Approvable for members 2 weeks of age or older for treatment of HIV infection who weigh less than 20 kg or who weigh 20 kg or more and are unable to swallow solid oral dosage formulations (i.e., capsules, tablets).

Vitekta

- ❖ Approvable for members 18 years of age or older for treatment of HIV infection when used in combination with ritonavir, another protease inhibitor and one or more other antiretrovirals

AND

- ❖ Member must be HIV treatment-experienced and unable to take other integrase strand transfer inhibitors (INSTIs).

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.

PA AND APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Pharmacy and click on [Other Documents](#), then select the most recent quarters QLL list.